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[integration] lessons learned



advancing
PRIMARY HEALTH CARE IN ALBERTA
sharing the learning

what is primary health care (PHC)?

Primary health care is the first point of contact of individuals with the health system – that is, where health services are mobilized and coordinated to promote health, prevent illness, care for common illness and manage ongoing problems (National Forum on Health, 1997). Primary health care services include: health promotion, illness and injury prevention, screening, health information, examinations, treatment in physicians' offices, vaccinations, home visits, nutritional counselling, drug dispensing, home care and so on. It involves a variety of health professionals including family physicians, nurses, public health nurses, nurse practitioners, pharmacists, mental health therapists, rehabilitation therapists, optometrists, home care providers, social workers and others.

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PREFACE

The Umbrella Alberta Primary Health Care Project was created to further advance primary health care by informing the practice of primary health care in Alberta and future policy development.

The Umbrella Alberta Primary Health Care Project finds its roots in the final report of the National Forum on Health (1997). The report recommended reform in key areas, including primary health care. It further recommended creation of a health transition fund to support evidence-based pilot and evaluation projects in health care. In response to those recommendations, the federal government created the Health Transition Fund (HTF) in 1997. It focused on four key areas:

- primary health care reform;
- integrated delivery of services;
- home care; and
- pharmacare.

Following consultation with stakeholders in 1997, Alberta Health and Wellness chose to focus on primary health care and submitted a proposal to the federal government. Alberta received an $11.2 million HTF grant in 1998 from the federal government, and the Umbrella Alberta Primary Health Care Project was created. An external selection committee reviewed primary health care project proposals from across the province, and 27 were ultimately recommended for funding. Most of the projects began in September 1998 and were completed by May 2000. Extensive dissemination activities by the Umbrella Alberta Primary Health Care Project and its 27 funded projects commenced in August 2000, including a provincial showcase conference and the development of diverse products to disseminate the learning. Detailed information on each of the 27 projects can be found at: **www.health.gov.ab.ca/key/phc/index.htm**

SHARING THE LEARNING

While the projects were diverse, a number of common themes emerged from the final project reports and evaluation reports. Key findings in the areas of primary health care delivery, integration, multi-disciplinary teams, access and quality were compiled in a series of booklets, as well as other publications, designed to share the findings provincially and nationally as a contribution to the advancement of primary health care.

It seems self-evident. For primary health care to best address the varied health needs of individuals and populations, services should be integrated. And in fact, "research supports the need for integration of a broad range of health and social services." (*Primary Health Care: Six Dimensions of Inquiry,* Howard Research Inc.) However, while integration is recognized as reasonable and beneficial, it is far from easy to achieve. This stand-alone booklet documents the key learning of the 27 Alberta primary health care projects on integration of services.

The other materials can be obtained through Communications Branch, Alberta Health and Wellness, 22 Floor, Telus Plaza North Tower, 10025 Jasper Avenue, Edmonton, Alberta T5J 2N3. Telephone 780-427-7164.

Alberta Health and Wellness extends its thanks to the project teams, regional health authorities, partners, the Evaluation Management Team (Howard Research Inc.) and the independent evaluation teams for their work in advancing primary health care in Alberta. It also thanks R.A. Malatest & Associates Ltd. and Dr. Leslie Gardner, who contributed to the development of this booklet, and our designers, Vision Design Communications Inc.



[integration] in primary health care

It seems self-evident. For primary health care to best address the varied health needs of individuals and populations, services should be **integrated**. And in fact, "research supports the (need for) integration of a broad range of health and social services." (Primary Health Care: Six Dimensions of Inquiry, Howard Research Inc.) However, while integration is recognized as **reasonable and beneficial**, it is far from easy to **achieve**.

Primary health care is the **first point of contact**, and usually the first level of care, that people have with the health system. This contact increasingly involves a range of health providers and focuses on an integrated, **multi-disciplinary team** approach. In this booklet, we explore the concept of integration as it applies to primary health care and summarize the **experiences** of the 27 primary health care projects in creating **integrated service delivery**.

The face of primary health care – Mike: A case for change

He appeared in the doorway, restless and dishevelled in multiple layers of women's clothing, and asked the nurse to look at the "splinters" coming out from the inside of his lanky body. As he lifted the layers of shirts, blouses and vests, he revealed weeping lesions of the worst infestation of scabies and body lice the Nurse Practitioner (NP)[1] had ever seen.

He said his name was Mike. He had no memory of his birthplace or his family. The staff at the city shelter said he had been living there for almost 15 years without any significant employment or relationship to those around him. Maybe it was because he avoided eye contact and talked crazy, especially when he responded to voices that no one else could hear. He said the voices told him to jump in front of trains and to kill people, but he didn't want to do what they said.

Few individuals, other than perhaps the worker at the shelter who admitted the homeless man each night, had any real contact with him that addressed his mental health and physical health needs. Based on their limited success engaging the homeless man, the shelter staff was encouraged by his growing ability to trust the NP. After three successive Thursday morning visits at the CUPS (The Calgary Urban Project Society) Outreach Clinic located in the shelter, he became open to considering treatment for his "splinters," medication for his schizophrenia and lotion for his infestation.

Within two weeks, he was interacting with people around him and his lesions were healing. He said his mouth was dry, but he wasn't hearing voices anymore. He was able to walk a few blocks away to the CUPS Community Health Centre where he underwent a full physical examination, including blood work, performed by an Alberta Mental Health Board (AMHB) physician. Following this, an application went forward to Assured Income for the Severely Handicapped (AISH) to cover the cost of his medication, including the anti-psychotic drug that CUPS had provided in the short term. He was referred to the Assertive Community Treatment Team (ACTT) of the AMHB to organize his finances and arrange for housing. Most notably, Mike wanted all of these measures to go forward.

Final Project Report, Integrating the Services of the Nurse Practitioner in the Inner City, CUPS Community Health Centre (The Calgary Urban Project Society meets the unique needs of an underserved inner-city population. In reference to the story above, the outreach multi-disciplinary team from the centre is comprised of a range of providers who strive to engage and build trust with the individuals at the shelter.)

1. A nurse practitioner is a registered nurse with advanced knowledge and skills in assessment, diagnosis and health care management. Typically, a nurse practitioner provides extended services for the diagnosis, treatment and/or referral of common disorders.

The face of primary health care – Natasha: A case for change

Natasha was a recent immigrant to Canada, raising her two young children on her own with limited financial resources. When Natasha brought her daughter to the Northeast Community Health Centre's (NECHC) Community Asthma Care Centre, the nurse educator discovered that there were health problems that extended far beyond the child's asthma.

Marion Relf, Site Director for the NECHC, described how the family was able to take advantage of the various services located at the centre. The Asthma Centre made sure that Natasha and her children were seen by a family physician on site. Then the Centre's occupational therapist for school-aged children was able to teach the girl to take deep breaths, which helped her use her asthma medication appropriately.

The nurse educator found that the child was not getting enough calcium, a complication of her disease and medications. The nurse educator called upon the centre's dietitian who explored with the child and the mother alternate sources of calcium and explained why calcium was an important part of the child's diet. The dietitian and the nurse educator uncovered that the family's financial difficulties were a barrier to improving their health status. The centre's social worker was able to help the mother more effectively manage her limited financial resources.

Through subsequent visits to the centre, the mother addressed her own depression with the assistance of the centre's mental health nurse and received help in dealing with her son's behavioural problems. These services made a tremendous difference in her family's health.

The Northeast Community Health Centre in Edmonton is based on a model of the delivery of primary health care by a multi-disciplinary team whose members (diverse health professionals) work together to address the complex health and social needs of individuals and families.

These compelling stories illustrate the benefits, to the individual being served and to the health system, of moving beyond traditional models of health care delivery to integrated service delivery. Integration involves the coordination and collaboration of various health professionals, as well as partners from other service sectors (e.g. justice, education, social services, housing) providing coordinated care to a population. The services provided depend on the needs of the population served. For example:

- The **Community Outreach in Pediatrics/Psychiatry and Education Program (COPE)** in Calgary integrated a team of mental health professionals with the school system to diagnose and treat children with mental health problems.
- The **Healthy Families Project** in the Capital Health Region was an intensive home visitation program for higher risk families with their first child. The project was delivered through a partnership with three community-based agencies.
- The **Lakeland Regional Health Authority's Integrated Community-based Palliative Care Project** created a palliative care team that provided advice to physicians, nurses and other caregivers in the community of Bonnyville.

In each case, the pilot project included and integrated those services that met the express needs of the community or population served.

THE BENEFITS

The commonly suggested benefits of integration include:

- increased user satisfaction through a holistic approach to care;
- improved diagnosis and coordination of care with resulting improvement in health status;
- increased focus on prevention of disease/injury, health promotion and wellness;
- increased cost effectiveness; for example, adding a mental health worker to a primary health care team reduces the need for costly emergency and urgent care;
- improved equity of service delivery by distributing responsibility for care among many providers.

(Primary Health Care: Six Dimensions of Inquiry, Howard Research Inc. 2000)

These benefits are accomplished through improved communication channels resulting in better coordination and diminished gaps and duplication in service delivery.

The nurse practitioner (NP) in the CUPS Community Health Centre, as noted in the earlier vignette, played a pivotal role as the link between medical professionals in the clinic and programs in the clinic and with other agencies providing health services. The NP acquired a depth of understanding about other CUPS programs and was able to exchange information, discuss patient/client issues that crossed program boundaries and work toward community strategies that address broad population needs within Calgary's inner city. The location of the service on-site at the shelter for the homeless and having a dedicated person providing care were key to gaining the trust of the patients/clients. As a result, continuity of care improved, duplication of service was reduced, unnecessary clinic visits were reduced, and clinic staff believed the health status of their patients/clients improved.

Evidence from the **Primary Health Care Collectives (PHCC) Project** in Edmonton showed much the same result for a very different patient/client population and a different service mix. PHCC targeted high-risk individuals living in the community through six teams consisting of a family physician, pharmacist and home care nurse manager. The focus was on improving the quality of medication use.



"On the face of it, it looked like he (child) had everything in place for him...great parents, a great school, a great doctor in the community and a good plan. But as we listened carefully to what the school principal had to say and the teacher, it became apparent that something was missing...We found as a result of meeting with everyone in the room (child, parents, the teacher, pediatrician, psychiatrist and community outreach worker) that part of his birth history that was known because he was adopted, was extremely significant for his educational programming. He'd had prenatal exposure to alcohol. His adoptive parents knew this, his doctor knew this, but no one had put this into the context of why this child was not doing well in school. Once the multi-disciplinary team got together and had that information, they worked through the process and were able to put better and more powerful interventions in place for him."

Dr. Margaret Clarke, COPE

"Individuals living in the community may see many health providers as they arrange for their own care – different physicians, different pharmacists and so on. And for most people, that works. But for high-risk individuals who are on multiple medications, there can be problems. Through our team approach, we were able to identify and resolve medication and compliance issues. And anecdotal evidence suggests that health care utilization was reduced for this group – fewer visits to the doctor, fewer hospital stays and fewer emergency department visits."

Karen Farris, Ph.D.,
Principal Investigator, PHCC

THE ROADBLOCKS

"You would think it would be easy. You would think that once you have a whole bunch of people together under the same roof, and they have clients in common, that they would just naturally work together...One of the things we learned in the evaluation was that it really isn't easy."

Micheline Nimmock, 8th & 8th Health Centre Evaluation Project
(Established in 1997, the Centre provides 24-hour, urgent medical care, mental health and public health services, and home care in Calgary's downtown core.)

Barriers to integration in the current health system include:

- focus on autonomy in professional cultures;
- lack of trust between professions and agencies;
- ambiguity of roles and responsibilities;
- inadequate information systems;
- lack of staff time to take on new responsibilities;
- silo effect of departmentalized leadership;
- absence of a process to facilitate integration;
- lack of formal evaluation criteria; and
- lack of incentives (particularly financial) to participate.

Compensation for professional services, not covered within established fee structures, was problematic for many projects. For example, the COPE program found that the fee schedule for physicians was a barrier to the integrated, team-based and preventive practices on which the program was based. Some physicians cannot bill for consultation with other health professionals unless the patient is present. However, the need for this type of consultation was evident in many of the complex cases of children with high health and mental health needs presenting at COPE.

As well, medical staff may not receive remuneration for public education, parent education and outreach functions, limiting the establishment of such programs or practices.



"Recruiting family physicians and pharmacists (for the teams) was problematic, as these individuals seemed overwhelmed with their current roles and obligations. Home care nurses were easier to recruit but had to fit these new responsibilities into current caseloads."

Karen Farris, Ph.D.,
Principal Investigator, Primary Health Care Collectives Project



what [works]

Successful integration is key to **effective primary health care**. A review of the 27 primary health care projects identified nine factors critical to successful integration.

A vision and goals must be agreed upon and internalized if integrated service delivery is to work.

MUTUALLY AGREED UPON AND CLEARLY COMMUNICATED VISION AND GOALS

The foundation for integrated service delivery is a common vision and goals. What it will look like, how it will operate, who it will include and what it hopes to accomplish must be developed with input from all stakeholders and participants. It is a time-consuming and often difficult process, but a vision and goals must be agreed upon and internalized if integrated service delivery is to work. The objective is to develop a sense of ownership and a common bond even among the most diverse participants.

During the planning phase for the Northeast Community Health Center (NECHC) in Edmonton, a vision, mission, operating principles and range of services were developed by a team that included community members, Capital Health staff, physicians, educators and independent consultants. But it doesn't stop there. The evaluation of the NECHC offers the following strategies for reinforcing the importance of the mission and vision:

1. Talk about the model frequently. Repetition is important. Use any opportunity to clearly identify how the model of service delivery flows from the vision and mission.
2. Make the model come alive by using vignettes to show how well it is working or how it might be expected to work.
3. Prominently display explanations and visual representations of the model in meeting rooms, hallways and service areas for review by patients, staff and students.
4. Ensure that anyone providing a service is fully oriented and has a working knowledge of the model of service.
5. Orientation about the vision, mission and model must be ongoing and address changes of staff, students and others at the Centre.
6. Consider the use of mentoring as a system to support orientation and learning about the model and vision.

Collaboration in Action: The Story of Edmonton's Northeast Community Health Centre (2000).

The strength of leadership will dictate how well the various components come together.

STRONG LEADERSHIP AND SUPPORT

Whether in the context of a community health centre or more broadly in providing primary health care to an entire region, the strength of leadership will dictate how well the various components come together.

The objective of the East Central Health Authority's **Primary Health Services Initiative** was to establish integrated primary health services in four rural communities. They credit the commitment and hands-on involvement of the CEO as key to helping the communities overcome the fears and misconceptions they had about the proposed initiative.

The project saw local managers as also having a leadership role. While the managers had great credibility in their communities, some were uncomfortable leading stakeholder meetings. They were given coaching and assistance in developing presentations, as well as assistance in developing clear messages.

Dedicated time was devoted to encouraging and fostering leadership activities at the NECHC (health leadership meetings, staff leadership). Further, the site director filled an important leadership role by maintaining focus on the vision/mission of the centre as well as implementing a participatory leadership approach.

LOCATION OF SERVICES

Having services located in one place (co-location) does not necessarily guarantee integration or collaboration, but can facilitate its development. Co-location was seen to be a key factor in fostering understanding of the roles of other team members, improved communication and cooperation, reduced duplication of effort and a simplified referral process.

"Opportunities [for collaboration] are here because of the structure. I can just run over and talk with them and exchange information."

Staff Member, Airdrie Regional Health Centre Evaluation Project (a multi-use community health centre that opened in the Airdrie community in 1998)

The Community Outreach in Pediatrics/Psychiatry and Education (COPE) Program team brought early identification; consultation with the child, family and teachers; case planning; assessment and referral directly to the school site. Being in the school enhanced the tracking of students and follow-up with parents. The team consultation provided physicians with ready access to information that would otherwise have been very time consuming to collect if the patient consultations were done in the doctor's office.

Many of the projects brought their services to the populations they served. The 8th & 8th Centre in Calgary serves three women's shelters; however, as this vulnerable population does not feel safe going out to access services, the centre dedicated a public health nurse to visit the shelters. The nurse addresses health care needs on site, links the women and children to other services and helps them with planning for the future.



"It (the project) was an opportunity for us to be creative, to be very thoughtful, and not to be trapped by some of the preconceived ideas that we have about roles or about our jobs. It was an opportunity to develop new and creative ideas for making a model that we can take to health policy makers and decision makers. We've been talking about it since about 1985, let's try to make it a reality. Let's try and make primary health care teams a reality and get on with providing better services."

Physician, Primary Health Care Collectives Project

WILLINGNESS TO COLLABORATE

For integration to be successful, there must be a willingness on the part of all stakeholders to collaborate. It must also be present in the governance level (management, board) and on the front line. Collaboration between stakeholders must follow through the planning stage into implementation.

COPE is an example of successful collaboration between the health, education and social service sectors. The initial collaboration between the Calgary Board of Education and the Alberta Children's Hospital has resulted in a program that has been successful in the early identification and treatment (within weeks instead of months or years) of children with high mental health and health needs.

In the **Primary Health Care Collectives Project**, some of the individual providers on the teams wrestled with territorial and other attitudinal issues that hampered collaboration – a home care nurse who didn't want her role changed, and a pharmacist and physician whose communication early in the project often did not include the home care nurse. Learning from the experience, Karen Farris, Ph.D., principal investigator for the project, stresses the importance of selecting the right people to work in an integrated environment; that is, those who understand and appreciate that other professions have something to offer, and who are focused on joint collaboration and goals.

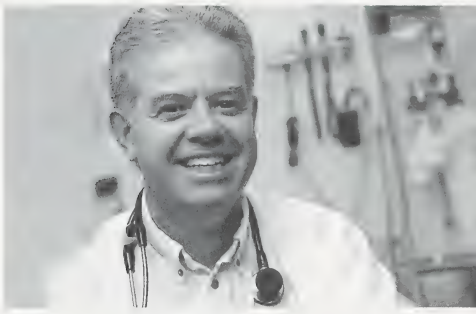
MUTUAL UNDERSTANDING OF ROLES AND RESPONSIBILITIES

Primary health care requires a shift in thinking from a provider focus, where responsibilities are distinct and separate, to a patient/client focus, where a variety of professions (both within the health sector and between sectors such as health and social services) must work together to address client needs. In some cases, it may mean redefining the boundaries between professions.

An early challenge for the CUPS Community Health Centre was confusion around the roles and responsibilities of the nurse practitioner as they related to the roles and responsibilities of nursing staff and physicians. An orientation manual was developed to differentiate the roles of the health team members, and team-building workshops were held to facilitate communication. Once a clear understanding was established with all involved, the integration of the new role progressed smoothly.

"…participants readily identified they had minimal knowledge of each other's roles, responsibilities and mandate. They function within separate functional units with different budgets, reporting structures and geographical catchment areas. No standardized structure or mechanism is in place for client-centred interdisciplinary collaboration… Thus, it was deemed important to devote time (during the model development process) to inform each other of their respective roles, mandates and service issues. This, in turn, served as a beginning step towards the objective of developing integrated and coordinated inter-disciplinary and inter-sectoral teams."

Airdrie Regional Health Centre Evaluation Project Report



"The different professions have traditionally taken their different roles and said, 'I do this and you do that' and never the twain shall meet. Primary health care is a specific idea that we work together so everyone who is able to provide good service to the patient for that problem can do it and do it very well."

Dr. Tom Szabo, Medical Director, 8th & 8th Health Centre, Calgary

TRUSTING RELATIONSHIPS

"Knowing your colleagues is a fundamental precursor to being able to trust those individuals; trust is a prerequisite for working with another in a multi-disciplinary and eventually inter-disciplinary milieu."

Collaboration in Action: The story of Edmonton's Northeast Community Health Centre (2000).

Trust between primary health providers and communities, individuals and families receiving services, between health professionals and professionals from other sectors, must exist to work successfully in an integrated environment. Trust was an issue between rural communities in the early stages of the **East Central Health Authority's Primary Health Services Initiative**. The communities believed that the project might be about taking services away. Trust was an issue in the CUPS program with the inner-city population that was wary of strangers. Trust was an issue among providers in many projects where roles and responsibilities were not well understood.

"Many community providers work in practices where they mainly interact with other providers via telephone and typically in a hurried manner. Face-to-face time discussing patient issues allows for clarity regarding comments/recommendations as well as trust. The trust and increased understanding of other professionals also provided an environment where alternative providers such as pharmacists and nurses can be more than an extension of physicians."

Dr. Karen Farris, Principal Investigator, Primary Health Care Collectives Project

Creating the team is only the first step.

MULTI-DISCIPLINARY TEAMS

A successful multi-disciplinary team depends on recruiting individuals with the right mix of skills and also the right personalities – those that show a willingness to collaborate, a dedication to the service delivery model and guiding principles.

During the screening phase of the **Primary Health Care Collectives Project**, all participants were asked about such things as dissatisfaction with the current system goals, ownership of the project and commitment to it. The process was successful in identifying that the project was not what one pharmacist was looking for, and they subsequently declined to participate. "More compelling was the fact that the one group whose answers had differed noticeably from the other groups later demonstrated the most visible problems of commitment to the project and to each other, which took some time and effort to rectify."
(Independent Evaluation Report, Primary Health Care Collectives)

Creating the team is only the first step. Team-building must be a deliberate and ongoing activity to help solidify the team and make them more effective caregivers as a team. Dedicated case conference time, as noted in an earlier example, is also a critical tool to help teams move beyond a side-by-side working environment to integrated team care.

Another component integral to the success of a multi-disciplinary team is providing incentives to encourage and support participation. Under a fee-for-service payment plan, particularly when meetings, public education and consultations are not covered, it is difficult to encourage physicians to participate in the activities required of a multi-disciplinary team.

For a more in-depth discussion of multi-disciplinary teams and specific keys to successful team-building, refer to the booklet *Multi-disciplinary Teams: Lessons Learned*, one of this series of primary health care booklets.



"Because there is a whole range of factors that can influence health, it is important that there is a whole range of different professions providing primary health care, and they all need to be working together in an integrated way."

Dr. Gerry Predy, Chief Medical Officer of Health, Capital Health Authority



APPROPRIATE INFORMATION MANAGEMENT

Many of the projects identified the lack of a common health record or information database as a barrier to integration. A common patient/client record that is accessible to the appropriate professionals, but remains confidential, allows for basic health information to be recorded, as well as comments from individual members of the multi-disciplinary team. A well-developed common patient/client record provides the framework for the multi-disciplinary team to manage patient/client care in a coordinated manner.

The **Lakeland Regional Health Authority's Integrated Community-based Palliative Care Program** implemented a "Communication Passport." The patient/client carried the passport to any appointments and/or physician visits. All the multi-disciplinary team members were encouraged to use the passport to document appointments, medications and pain and symptom management.

A complex information system is not always necessary to provide coordinated information sharing. The **Northeast Community Health Centre** in Edmonton instituted a paper record that provided the basis for sharing patient/client information among diverse health professionals. The **Community Outreach in Pediatrics/Psychiatry and Education (COPE) Program** (Project) made use of the family liaison worker to coordinate information and share it among the members of the team as appropriate, ensuring attention to confidentiality issues.

"The important factor is that some mechanism exists so that all members of the team have access to the same client information, and are able to share the information they collect, while maintaining confidentiality and reducing the number of times a client has to repeat information."

Marion Relf, Director, Northeast Community Health Centre in Edmonton

FORMALIZED COMMUNICATION

Formal communication channels need to be developed and the process of communication agreed upon, so that everyone involved stays fully informed. Communication can take the form of public awareness campaigns, team meetings, reports, Internet-based communication or common health records.

When planning, open channels of communication among all stakeholders are key to the development of a common vision, mission and goals of the community, as well as to managing the expectations of stakeholders with differing agendas.

In the early planning stages for the Airdrie Regional Health Centre, communication and consultation sessions were held with the community on after-hours medical care. The community expressed a clear desire for 24-hour access to emergency services. Subsequent media coverage solidified the public perception that the Calgary Regional Health Authority (CRHA) was committed to providing this service. Later in the planning process, community physicians said that from their perspective, this service was not necessary in the community. The result was a complex communications/public relations issue for the CRHA. The evaluation of the process stressed the importance of including key stakeholders (in this case the community's physicians) in the early planning and communication stages of the project.

Communication between those who refer and those who provide service is critical to successfully integrating services along the continuum of care. The Diabetes Education Services in the Capital Health Region found that the majority of physicians were unaware of the range of services available and the location of clinics. As a consequence, they often referred patients/clients to programs that were located a distance away, when a more appropriate service was available closer to the patient/client's home. The evaluation recommended an aggressive marketing/communication strategy to inform physicians about the range and location of available services.



when it's [working]

The health system in Alberta is moving towards integration. Although integration exists at many levels throughout the health system, full integration will likely be a slower process. These 27 projects represent a step in **the right direction.**

But how do we know when integration has been achieved and how do we maintain it?

The Northeast Community Health Centre in Edmonton established the following set of indicators of integration:

1. Understanding respective roles and responsibilities of team members.
2. Linking people with the practitioner most able to meet the identified health need.
3. Functioning as a team to ensure that the complement of professionals most suited to the need are working together.
4. Designating one professional as the primary provider (depending on the particular needs of the patient/client), encouraging a relationship with the provider most able to address the health needs.
5. Using evidence-based practice where possible to provide continuity of care.
6. Using an integrated clinical record that shares assessment and treatment information among providers, reduces duplication of service, addresses priority issues and transfers care from one provider to another.
7. Arranging for all required services to be provided at one time when appropriate and desired to reduce repeat visits.
8. Using case conferences for effective coordination and planning among professionals, and with those seeking services.

(Summarized from the Northeast Community Health Centre Conceptual Model)

"Primary health care is a relatively old concept that started about 20 years ago with the World Health Organization. It's designed to bring together all the different sectors of health care into one working unit. So that when the patient enters the system at one point, they encounter a large team of people that are well connected, well integrated, that know each other very well so that they get the best service from the right person at the right time."

Dr. Tom Szabo, Medical Director,
8th and 8th Health Centre, Calgary

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www.health.gov.ab.ca/key/phc/index.htm

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